DIVISION OF PROFESSIONAL REGULATION

CANNON BUILDING
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DOVER, DELAWARE 19904-2467

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Application Number: _____

Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals

APPLICATION FOR LICENSURE

1. **Full Name**: _____

2. **Mailing Address**: _____

   _____Zip Code:_____

3. **Phone:** Business (____) ____-_____ Home (____) ____-_____ **Email:** _____

4. **Social Security Number:** _____-____-_____

5. **Applying for Licensure as** (check one):

   ____ Licensed Professional Counselor of Mental Health (LPCMH)

   ____ Licensed Associate Counselor of Mental Health (LACMH) (Requires "Written Plan for Supervised Clinical Experience." (Form is available on the Board's web page or Board office).

   ____ Licensed Chemical Dependency Professional (LCDP)

6. **Applying for Licensure by** (check one):

   _____ Certification

   _____ Reciprocity (Requires "Verification of Licensure from Another State" and "Affidavit and Release for Reciprocity Application." (Forms are available on the Board's web page or Board office).

7. **Other State Licensure/Certification/Registration**: Please list all mental health-related state licenses, certifications and/or registrations - current, inactive and/or expired - that you currently hold or have held in the past, in Delaware and/or any other state. (Use additional pages if needed.)

State	Type of License, Certification or Registration	Number	Dates

8. **National Certifying Organization**:

Name of Certifying Organization	Certification Number	Date Certified	Expiration Date
NBCC			
ACMHC			
DCB INC or NAADAC			
Other Certifying Organization	(Requires completion of "Other Certifying Organization Form," available from the Board office.)		

9. **Graduate Education** - Please list mental-health-related graduate degrees below. (Use additional page if needed.)

Degree	Date Awarded	Educational Institution Granting Degree	Field of Study

10. **Summary of Professional Counseling Experience and Clinical Supervision by Setting/Location:** Please complete the following table:

No.	**Name of Setting/Location*** in which Professional Counseling Experience and Clinical Supervision were acquired	**Dates** From	To	**Number of Hours** of Professional Counseling Experience/Supervision: Unsupervised Professional Clinical Counseling Experience	Supervised Professional Clinical Counseling Experience*	Face to Face Clinical Supervision
1						
2						
3						
4						
5						
Total Number of Hours of Professional Counseling Experience/Clinical Supervision						

***Minimum 1,600 hours of clinical supervised experience, at least 100 hours of which shall consist of face to face clinical supervision.**

Please note: You must complete the attached "Setting/Location Information Form" for each setting/location listed.

11. **Graduate Credit Alternative**: <u>(Not available to Licensed Chemical Dependency Professionals).</u> If you wish to substitute 30 post-Masters credit hours <u>in</u> the field of counseling for 1,600 hours of Professional Counseling Experience, please answer the following:

Educational Institution: ____

Dates: ____________________________________ Number of Credits Earned: _____________

(Please Note: If you use this option, you must have the educational institution send a transcript showing graduate credits directly to the Board office.)

Please note: When your application is <u>complete</u>, please allow 4-6 weeks to receive your license. A <u>complete</u> application is one that includes all required documentation and correct payment.

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I certify that the information provided in this application is accurate and complete to the best of my knowledge and belief. I understand that the State of Delaware, Board of Professional Counselors of Mental Health and Chemical Dependency Professionals has the right to deny or revoke licensure if my application contains fraudulent information. I also understand that this application, if incomplete, will be considered null and void one year after receipt by the Board of Professional Counselors of Mental Health and Chemical Dependency Professionals.

I hereby authorize any administrative supervisor, clinical supervisor, designated objective agent and/or other person listed as a reference in this application to release any and all information relevant to my qualifications as a mental health counselor, including, but not limited to, my education and training, professional counseling experience, professional history, character and ethics to the Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals.

____ ___________________________

Signature of Applicant Date

Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals

SETTING/LOCATION INFORMATION FORM

Please complete one of these forms for each setting/location in which you acquired your professional counseling experience and clinical supervision, as listed in Question 10 on the "Application for Licensure." Please photocopy this form as needed.

1. **Your Name**: _____

2. **Setting/Location**:

   A. Setting/Location Number (from Question 10 on Application): _____

   B. Setting/Location Name: _____

      Address: _____

   C. Description of Setting/Location (for example, private/group practice, community mental health agency, elementary school, etc.): _____

   D. State Business License Number (if self-employed): _____

3. **Professional Counseling Experience in this Setting/Location**:

   A. Dates of Professional Counseling Experience: From _____ To _____
   (Must not exceed a four (4) year period for LPCMH and LACMH applicants.)

      Number of Hours of **Unsupervised** Professional Counseling Experience: _____

      Number of Hours of **Supervised** Professional Counseling Experience: _____

      Total Number of Hours of Professional Counseling Experience: _____

   B. Job Position/Title: _____

   C. Job Responsibilities and Activities (use additional page if needed): _____

_____

_____

_____

   D. Verification of Professional Counseling Experience in this Setting/Location: Who will verify your professional counseling experience? (Check one.)

      Clinical Supervisor _____

      Administrative Supervisor _____

      Designated Objective Agent (for Self-Employed Applicants) _____

Name: _____

Title: _____

Address :_____ Phone: _____

_____ Zip Code: _____

4. **Face to Face Clinical Supervision in this Setting/Location**:

A. Please complete the following table:

Name of Supervisor	Type of Supervision	**Number of Hours of Face to Face Supervision**
	(a) Individual Supervision:	
	(b) Group Supervision:	
	(c) Individual Supervision:	
	(d) Group Supervision:	
(e) Total Individual Clinical Supervision in this setting/ location: [(a) + (c)]:		
(f) Total Group Clinical Supervision in this setting/location: [(b) + (d)]:		
(g) Total of All Clinical Supervision in this setting/location: [(e) +(f)]:		

B. Name of Clinical Supervisor: _____

Address: _____Phone: _____

_____ Zip Code: _____

Degree: _____ Type of License: _____
(e.g., LPCMH, LCSW, LCDP, Psychologist, Psychiatrist)

License #: _____ State: _____ Date of Licensure: _____

C. Name of Additional Direct Supervisor: _____

Address: _____ Phone: _____

_____ Zip Code: _____

Degree: _____ Type of License: _____
(e.g., LPCMH, LCSW, LCDP, Psychologist, Psychiatrist)

License #: _____ State: _____ Date of Licensure: _____

D. Name of Additional Direct Supervisor: _____

Address: _____ Phone: _____

_____ Zip Code: _____

Degree: _____ Type of License: _____
(e.g., LPCMH, LCSW, LCDP, Psychologist, Psychiatrist)

License #: _____ State: _____ Date of Licensure: _____

Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals

AFFIDAVIT

The undersigned applicant for Professional Counselor of Mental Health or Chemical Dependency Licensure, being sworn, deposes and affirms that she/he meets the following Qualifications for Licensure as stated in Title 24 *Delaware Code*, Chapter 30:

The applicant is not the recipient of any administrative penalties regarding his/her actions as a licensed, registered or certified mental health provider, and has not entered into any "consent agreements" containing conditions placed upon his/her professional conduct, including voluntary surrender of license;

The applicant does not have any impairment related to drugs, alcohol, or a finding of mental incompetence by a physician that would limit the applicant's ability to safely act as a LPCMH, LACMH; or LCDP.

The applicant has not been convicted of a felony and does not have any criminal conviction or pending criminal charge which is substantially related to the fitness or ability to perform one or more of the duties or responsibilities necessarily related to practice as a LPCMH, LACMH; or LCDP.

The applicant has not been penalized for any willful violation of any code of ethics or professional mental health or chemical dependency counseling standard.

The applicant further states that she/he has not violated any rule or regulation set forth by the Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals.

_____
Signature of Applicant

State of _____

City of _____ County of _____

Sworn to me before me this _____ day of _____, 20____.

My commission expires on _____.

_____
Signature of Notary Public